WESTERN TIDEWATER COMMUNITY SERVICES BOARD

Serving the cities of Franklin and Suffolk and the counties of Isle of Wight and Southampton

Executive Director
5268 Godwin Blvd.
Suffolk, VA 23434
Phone (757) 255-7136
Fax (757) 255-7142

Human Resources
Phone (757) 255-7100
Fax (757) 255-7115

Finance Office
Phone (757) 255-7118
Fax (757) 255-7139

Quality Assurance
Phone (757) 255-7125
Fax (757) 255-7138

Franklin Services
200 E. Second Avenue
Franklin, VA 23851
Phone (757) 562-2208
Fax (757) 925-2296

Smithfield Services
1801 S. Church Street
Suite 6
Smithfield, VA 23430
Phone (757) 357-7458
Fax (757) 356-1808

Suffolk Center
Northgate Building
Godwin Commerce Park
1000 Commercial Lane
Suffolk, VA 23434
Phone (757) 942-1069
Fax (757) 925-2213

Pathways
Northgate Building
Godwin Commerce Park
1000 Commercial Lane
Suffolk, VA 23434
Phone (757) 942-1099
Fax (757) 925-2210

Main St. Opportunities
22229 Main Street
Courtland, VA 23938
Phone (757) 653-0257
Fax (757) 653-0805

Tidewater House
5268 Godwin Blvd.
Suffolk, VA 23434
Phone (757) 255-7131
Fax (757) 255-7128

Saratoga
135 S. Saratoga Street
Suffolk, VA 23434
Phone (757) 925-2222
Fax (757) 925-3569

February 20, 2018

RECEIVED
FEB 21 2018
VDH/OLC

Ms. Kathy Sandusky, LTC Supervisor
Division of Long Term Care Services
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

RE: The Wilkins
Suffolk, VA
ICF/ID #49-G038

Dear Ms. Sandusky:

Enclosed please find Western Tidewater Community Services Board's Plan of Correction addressing the deficiencies cited as a result of the unannounced Medicaid survey at The Wilkins ending January 29, 2018.

If you have questions or comments, please contact me at 757-274-4730; by fax at 757-673-2586; or drawls@wtcsb.org.

Sincerely,

Darlene W. Rawls, M.Ed., Director,
Community Integration and Rehabilitation Services
Western Tidewater Community Services Board

Enclosure(s)

DWR:rm

cc: Demetrios Peratsakis. Executive Director, WTCSB
Cheryl Collier, QA Director, WTCSB

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G038	A. BUILDING _____ B. WING _____	01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKINS, THE	437 JACKSON STREET SUFFOLK, VA 23434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
E 000	Initial Comments The unannounced Emergency Preparedness survey was conducted on 01/25/18 through 01/29/18. Corrections are required for compliance with CFR Part 483.73, 483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Disabilities (ICF/ID). The census in this 4 bed facility at the time of the survey was 4. The survey sample consisted of 2 current Individual records (Individual #1 through #2).	E 000		
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm	E 015	1) Facility Policy #920 Emergencies, was revised to include Sewage System Failure. It reads: "In the event facility staff note sewage backup and/or failure facility staff should immediately call on-call support to secure contracted plumbing services. 1. Sewage failure may be indicated by gurgling or poor flushing toilets, poor drainage of sinks and showers, any noted sewage backup in any drain and/or any odor of sewage. Facility staff noting any of these single or multiple occurrences should utilize a plunger and if plunging does not work they need to immediately contact on-call support services to access a plumber. Facility staff should shut the water off to the toilet and/or sink in that area to prevent run-off until contract services are secured. Toilet and sink cut-offs are connected to the wall under or behind the sink or toilet. Cut-off is gained by twisting the knob clockwise. 2. If facility staff notice multiple drains and/or toilet are not flowing properly and/or backed up water should be shut off to all	02/2018

LABORATORY OIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dir 2/20/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 015	Continued From page 1 systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on staff interview and facility Emergency Preparedness Policy review, the facility staff failed to develop policies for the disposal of sewage and waste. The findings included: During the review of the facility's Emergency Preparedness Plan on 1/26/18, there was no documentation that the emergency plan included policies and procedures to provide for sewage and waste disposal. During an interview on 1/26/18 at 10:30 A.M. with	E 015	those areas following the above methods in step number one and contact the on-call support for plumbing assistance. 3. Depending on the cause of sewage backup the facility and contractor may need to have the T-pipe directly unstopped from the facility that runs directly into the main sewage line flowing from the facility to the city sewage or septic tank this may include the contacting of the City's Public Works and/or private contractor to pump a septic tank. 4. In the event the sewage emergency requires more than 8 hours to repair and/or it occurs after hours and contract services cannot be secured the facility must facilitate Policy #921 Emergency Evacuation Procedures." 2) All facility staff will receive Emergency Preparedness training to include a review of the revised policy, a walk through of the facility's shut-off valves, as well as implementation of the policy via table top exercises. Per Policy #941 Staff Orientation/Training, this training is required of all facility staff at hire and annually thereafter. Evidence of staff training will be maintained in staff training records of the personnel files.	03/15/18

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E 015	Continued From page 2 the Residential Coordinator, she stated no policy and procedures had been developed as part of the facility's Emergency Preparedness Plan for sewage and waste disposal. The facility staff failed to include policies and procedures to provide sewage and waste disposal.	E 015		
E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.475(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on staff interview and facility Emergency Preparedness Plan Policy review, the facility staff failed to ensure that a communication plan for sharing information with families or representatives was in place. The findings included: During the review of the facility's Emergency Preparedness Plan on 1/26/18 there was no documentation that resident families or representatives had been given information regarding the facility's Emergency Preparedness Plan.	E 035	1) The facility provides information to families/authorized representatives regarding the facility's Emergency Preparedness Plan within 30 days prior to admission per Policy #837 Admission Overview. Per this policy, facility staff review the Individual Orientation Checklist which includes Orientation Goal #4: "Explanation of Fire Detection System and equipment including identification of evacuation exits, fire alarm pull stations, audio/visual alarms and smoke detectors. Also shown location of evacuation site." 2) The facility provides information to families/authorized representatives regarding the facility's Emergency Preparedness Plan via the Person Centered Plan, developed at admission and updated at least annually. Part I of the Person Centered Plan, Essential Information, includes emergency contact information. Also, the "Back Up Plan" section of Part I includes description of "plans that will be followed if support cannot be provided as agreed (such as when staff are unavailable or in the event of an emergency)." 3) The facility shared information about the Emergency Preparedness Plan with each	02/19/18 03/15/18 03/01/18

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E 035	Continued From page 3 During an interview on 1/26/18 at 10:30 A.M. with the Residential Coordinator she stated neither families nor representatives had been given information regarding the facility's Emergency Preparedness Plan. The facility staff failed to provide information to the families or representatives regarding the facilities Emergency Preparedness Plan.	E 035	Individual's authorized representative/legal guardian via letter. The letter provided the address of WTCSB's designated Command Center and explained that in the event of an evacuation to the command center or other site, they would be contacted via telephone with information regarding the evacuation site, emergency numbers to contact facility staff, and the intended duration of the evacuation.	
W 000	INITIAL COMMENTS An unannounced Fundamental Medicaid survey was conducted on 01/25/18 through 01/29/18. Corrections are required for compliance with CFR Part 483 Intermediate Care Facilities for Individuals with Disabilities (ICF/ID) Federal Regulations. No complaints were invesigated during the survey. The Life Safety Code report will follow. The census in this 4 bed facility at the time of the survey was 4. The survey sample consisted of 2 current Individual records (Individual #1 through #2).	W 000	4) Facility Policy #921 Emergency Evacuation Procedures was revised to include "In the event of an evacuation to the command center or hotel each individual's authorized representative or legal guardian will be contacted via telephone with information regarding the evacuation site, emergency numbers to contact facility staff and the intended duration of the evacuation." The revised policy will be reviewed with all facility staff during Emergency Preparedness Training.	02/2018 03/15/18
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility staff failed to hold evacuation drills under varying conditions including various times of the day or night.. The findings included:	W 441	1) Facility Policy #922 Fire Drill Evacuation was revised to include "Drills on each shift should vary in times." 2) Facility staff will receive training to review the revised Policy #922 Fire Drill Evacuation. The Evacuation Drill Record (Form #1921) will also be reviewed to highlight that distribution of the original is required to the manager for review before filing. Evidence of staff training will be maintained in staff training records. 3) The facility manager will review the	02/2018 03/15/18 03/15/18

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W 441	Continued From page 4 A review of the facility's evacuation drills indicated the following: 12 A.M. - 8 A.M shift 01/14/18 -5:45 A.M. 12/03/17 - 5:30 A.M. 11/15/17 - 6:30 A.M. 10/28/17 - 5:30 A.M. 09/19/17 - 6:27 A.M. 08/26/17 - 5:30 A.M. 07/25/17 - 6:19 A.M. 06/18/17 - 6:00 A.M. 05/17/17 - 6:48 A.M. 04/23/17 - 5:45 A.M. 03/25/17 - 6:03 A.M. 02/21/17 - 6:15 A.M. 01/29/17 - 6:00 A.M. 12/04/16 - 5:05 A.M. 11/27/16 - 5:30 A.M. A review of the facility's Policy and Procedures revised 11/7 indicated: "It is the policy of the facility that fire drills will be completed quarterly on each shift to maintain individuals served and staff awareness of evacuation procedures. In addition to the fire drills and the completion of a Life Safety Code bi-annually the facility contracts an annual fire agreement with and outside service provider to inspect all fire equipment." Procedure: 1. On each shift quarterly staff will activate the Fire Emergency System by manipulating a pull station to sound alarms. Once alarms are sounded staff will assist and or direct all individuals to the designated evacuation site (light post far corner of parking lot) outside the facility	W 441	Evacuation Drill Records (Form #1921) at least quarterly to ensure drills are performed at varying times on each shift.	

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W 441	Continued From page 5 using various evacuation routes/egress in various types of weather conditions. 3. At the completion of the fire drill staff will document the date, time, the amount of time, individual's names, weather conditions and any other concerns on the Evacuation Drill Form (Form #1921). During an interview on 1/29/18 at 11:07 A.M. with the Residential Service Coordinator, she stated Evacuation Drills were not conducted at various times on the 12-8 shift. The facility staff failed to conduct evacuation drills during various times of the day or night.	W 441		